

BACKGROUND

On March 17, 2014, the Centers for Medicaid and Medicare Services (CMS) promulgated new federal regulations for Home and Community Based (HCB) Waiver Service Settings requirements. The federal regulations are 42 CFR 441.301(c)(4)-(5). CMS posted additional guidance to help states assess compliance and remediate areas that are not fully in compliance. More information on the rules can be found on the CMS website at www.medicaid.gov/hcbs.

GATHERING INPUT

Each waiver that requires a transition plan has one posted online. The summary plan for the state was also part of the public comment period. Public comment was taken from October 3, 2014 through November 3, 2014. The public was invited to submit comments through an email address (bhdmail@wyo.gov) and forums were held at six locations across the state (Laramie, Cheyenne, Jackson, Evanston, Sheridan and Casper). A presentation on the state's transition plan was conducted at this year's Mega Conference and a recording was posted using YouTube, and the link was on the Division's website for people who couldn't attend in person. Two conference calls were held for people during the 30 day period so they could call in with their comments. A newsletter with information on the Transition Plan and forum schedule was sent to all waiver participants or guardians and information was sent out to nearly 2,000 people on the Division's listserv. The transition taskforce, which has members from various roles within the waiver system, reviewed and discussed input collected to help make final changes to the Transition plan.

SUMMARY FORMAT

Public comments are grouped in this document by topic, and comments of a similar nature may be grouped together with a single response provided for each group. Comments from a single person that covered multiple issues may have been divided into topics as noted above; however, written comments are included verbatim, with the exception that general comments (such as thanking the department for the opportunity to comment) were removed. Comments received in-person were paraphrased based on notes taken by staff at the forums.

TOPIC	General Comments about the new rules and requirements
COMMENTS RECEIVED	<ul style="list-style-type: none"> <i>It is like vote for this Bill and we'll see what is in it. This will be monstrously expensive.</i> <i>This is regulating areas that do not need to be regulated. Is our current system so flawed?</i> <i>Do the Feds need to subject this on the whole United States?</i> <i>Who in Washington has the knowledge? This is out of control. Cannot be one size fits all.</i> <i>Somewhat force fed...What happens with Affordable Health Care is forcing all companies to comply.</i> <i>What are you going to do with increased cost and no more money? We may lose all our providers.</i> <i>Fixing problems that no one had. These are made up problems that don't exist.</i> <i>Do we have the capability to go back to the Feds and state this is not workable? Feds don't allow comments?</i> <i>Our State Government robbed the Disability Fund</i> <i>Where is the Constitutional Authority to make these changes?</i> <i>Because all States have to do something doesn't make that something correct. Nazi Germany required all Cities to do the same thing in regard to the Jews. That did not make it right.</i> <i>There must be a way to apply to an exception on every rule, a way to appeal to an independent authority. There is not one size fits all. What ever happened to choice?</i> <i>CMS rules are broad, and appear to give a great deal of latitude to states in how they are to be implemented. We would ask that the BHD not to become overly prescriptive in its interpretation of the rules, require more than the federal government intended, or disallow settings not specifically stipulated in the rules.</i>

	<ul style="list-style-type: none"> <i>The goals and ideals of this federal rule and approach to implementation is laudable and has many merits to its pursuit. Ideas and concepts like independence, full integration, jobs for all who desire one, and so on are ones that arguably most involved in this system support and strive to provide daily. Our organization is working diligently to make the proper changes to our operations and philosophies to align with these new standards.</i>
STATE RESPONSE	<p>The federal regulation aims to improve the quality of life for many individuals receiving HCBS. The rules were open for public comment and revised due to the public comment received. The intent is to expand opportunities to receive supports in the most integrated setting, and ensure that individuals have access to community living to the same extent as individuals not receiving HCBS. Further, the intent is to ensure that individual rights are not unduly restricted. The rules are broad and focus on an individual's experience, but the state did try to work with the Transition Task Force to develop a way to quantify or measure "access to community", "integration", and "isolating" in order to do the setting analysis. We did not intend to be more prescriptive and used the additional guidance provided by CMS in their "toolkit" in order to examine our settings and develop the flags. The state standards were developed to help interpret the rules and proceduralize how we would want providers to ensure they are meeting the new standards.</p>
TOPIC	Input on the Process to Analyze Settings and Develop Transition Plans
COMMENTS RECEIVED	<p>Setting Survey issues</p> <ul style="list-style-type: none"> <i>The preliminary results of the provider setting survey may be inaccurate. We completed the survey based on the questions posed, but the questions in our opinion were flawed. As an example, one of the questions asked if people carried their own keys. A more accurate question would have been "do people have the opportunity to carry their own key." We would have answered that every single person for whom we provide residential support has the opportunity to carry their own key, but because the question was worded differently, we had to answer based on the fact that some people chose not to have a key, therefore do not carry a key.</i> <i>It is mentioned in the summary document that 333 locations were surveyed and only 12 were in compliance with the proposed changes. I believe that this alone should be an indication that maybe these "Idealistic" proposals are economically "Unrealistic" and CMS should be propositioned for exceptions, unless the Department of Health is going to substantially increase funding to cover the additional costs of these "Idealistic" proposals. Also, it would only be fair for the Department of Health to assume the \$3,000,000 of long term debt that NOWCAP is carrying to provide these facilities that would no longer be usable because of non-compliance.</i> <i>Not a good public HCBS Survey.</i> <i>344- is that all ID locations?</i> <i>We feel the state standards are over reaching and could cause negative either intended or intended consequences. Because this is not a federal requirement, who will offset the financial losses if buildings have to be sold? Why do this in the first place? And finally we feel strongly that there is an appeal process in place that does not offer the Department of Health the final say on what settings meet the requirements set forth. This could even include members from CMS as we feel that State through this proposed transition plan is more stringent and extreme when compared to the federal requirements and intent of the rules.</i> <i>How can we be expected to adhere to these requirements under the new rules. This is contradictory. Furthermore, it has been determined that several facilities around the state of Wyoming are "isolating". This may be because of the location of the facility, or the lack of community involvement for the participants. I have to say that I am grateful that evidence is being looked at to ensure that our folks are not being isolated and are being integrated. I don't buy the location issue one bit. It wouldn't matter if a facility was 20 miles out of town, either community integration is taking place, or it is not. This is what needs to be looked at.</i>

STATE RESPONSE	<p>The provider setting survey was developed using the CMS guidance on settings that presume to isolate people, from other state surveys, and the knowledge of settings in Wyoming. The questions were worded based on these items and quality checked by an expert in survey design from the Director's office. Providers will be issued follow up questions in order to better examine whether the setting requires a flag/corrective action based on the provider's response.</p> <p>The Division did not intend to have a large number of settings fall under the category of noncompliance. The initial settings analysis did use location information for industrial zones or locations that are over 2 miles from a community area as a setting that will not be in compliance. The discussion to include those areas as "non-compliant" came from a review of CMS guidance on questions to evaluate for settings and a discussion with task force members and state staff on settings where people can safely walk in the neighborhood, access other nearby businesses, have visitors from the general public, and have transportation options to access the community when they want to.</p> <p>Based on the comments received, we have modified the settings analysis to eliminate ruling out a setting due to an industrial park or commercial zoning location. We do not feel the expectations are too idealistic, rather, we are asking questions that align with CMS's requirement to analyze all HCB settings in our state.</p> <p>Wyoming's transition plan outlines a process of assessment that will be based on examining the characteristics of HCBS rather than relying solely on location, size, physical structure, or geography. Compliance will be determined based on the opportunities and experiences of the members receiving HCBS, according to the standards set in the federal regulation, including but not limited to whether the individual has selected the setting from all available choices; whether the individual's rights to privacy, dignity and respect, and freedom from coercion are protected; whether the individual has choice in services and providers; whether the setting is integrated in and facilitates the individuals access to the greater community; whether the person has a choice of roommates, has freedom to control their own schedules and activities, and may have visitors and access to food at any time.</p>
COMMENT	<p><i>Legislative involvement</i></p> <ul style="list-style-type: none"> <i>Are there Legislators on this Transition Committee?</i>
STATE RESPONSE	<p>There are no legislators on the Transition Task Force. Members of the Joint Labor committee received the transition plan drafts and we plan to send more communication of the transition plan needs to the Wyoming legislature as we get approval.</p>
COMMENTS RECEIVED	<p><i>Funding concerns</i></p> <ul style="list-style-type: none"> <i>Difficult to write a detailed action plan with no providers able to provide.</i> <i>What is the expectation from the State when no money is out there right now and we have this time line?</i> <i>Who is going to pay for the action plan requirement? The State? The clients? The providers, who can't make now because of the waiver re-designs?</i> <i>From my experience if all waiver recipients were funded and staffed adequately there would be more freedom of choice in activities. The staffing ratios and lack of funding make it impossible to allow one resident to attend a function because all residents would have to attend. Most of this proposal comes off as throwing out the baby with the bath water. The changes are doing away with what is working and instituting changes that will only cause problems.</i> <i>Funding. The current model for funding services to participants and the rates which providers are paid for services is simply inadequate. Consideration needs to be given to the highest need participants and those who require significant supports. While I do not agree with the strategy I understand why the Department of Health is pursuing policies which de-incentivize services to the highest need people. To implement the new waivers and ultimately this mandate regarding settings will cost the State of Wyoming more than it is currently spending and both the legislative</i>

	<p><i>and executive branches need to face that reality and provide the necessary resources or people with continue to be underserved and ultimately lose services from willing and qualified providers.</i></p> <ul style="list-style-type: none"> <i>• Where is the money coming from for these expensive services?</i> <i>• Standards can be simply defined as an expectation or established rules that must be met. The ability to truly implement the above standards if set as rules that must be met will cause difficulty if truly implemented as rules. These standards would be unobtainable anywhere in the nation without proper funding in place. We feel that may be better off by meeting the basic requirements set forth by CMS before we implement even more restrictive rules. Although this all sounds great and we at CES agree with the concepts, we will be asking the impossible.</i> <i>• With providers getting cuts, there is a feeling that providers just can't break even. This is a serious point of concern from the commenter's perspective. Example that providers are paid for 1:3 but they provide 1:1 staffing ratio</i> <i>• Vocational rehabilitation and state pushing employment but not getting more funding. When will there be more funding available for employment outcomes?</i> <i>• Limitations on what providers can pay staff. Cannot do some of these things at the current rates and can't get the staff.</i> <i>• This is asking a lot. Things will need to change to accommodate these changes</i> <i>• Settings free of any type of schedule would be difficult to implement from a financial standpoint requiring on-demand, 1:1 staffing for more involved participants.</i> <i>• Concerned that doctor orders or team decisions will not be taken into consideration. There is a concerned of the increased cost to providers in terms of staffing and increase cost of food to clients.</i> <i>• This will require more staff and vehicles.</i>
STATE RESPONSE	<p>The state understands the new standards may require more individualized services and flexible staffing responses to honor people's choices in a non-regimented or unplanned manner. Members of the Joint Labor committee received the transition plan drafts and we plan to send more communication of the transition plan needs with the Wyoming legislature as we get approval. It will be important for providers, participants and families to also communicate any concerns with funding to their legislators. The transition plan milestones involve many tasks that need to be done to work on areas identified as out of compliance.</p>
COMMENTS RECEIVED	<p><i>Timeline</i></p> <ul style="list-style-type: none"> <i>• This five year plan needs to be slowed down and community input needs to be taken in to account. This is a diverse State and this plan is a very adversarial way to manage diversity.</i> <i>• We feel the transition plan timeframes are more aggressive than necessary and the State may benefit from reviewing other State developed plans.</i>
STATE RESPONSE	<p>Other State's plans have been reviewed. The state listened to several trainings on the new rules by CMS and feel that some of the changes required with the new standards should not take the full five years to implement. The Task Force agreed. The milestones will involve training, education and technical assistance with providers, participants and families so that we can meet our deadlines.</p>
COMMENTS RECEIVED	<p><i>Educating Participants and Families</i></p> <ul style="list-style-type: none"> <i>• How will we educate participants, in language they understand, about these changes?</i> <i>• How are individuals going to learn about these new rights? I attended a public meeting to explain these in Jackson yesterday. That was fine except not one person in the audience is living in an institution. There was a staff member from CES who left less than 10 minutes after the start. WHO is telling the clients of these providers about the new rules? I do not see the providers doing it?</i> <i>• Education of guardians and case managers is needed to remove many restrictions on waiver</i>

	<p><i>participants which providers are expected to enforce but are not in agreement with.</i></p> <ul style="list-style-type: none"> <i>• We need to do more general public education regarding disabilities?</i> <i>• Guardianship training issues. Guardians either are not involved in choices, too involved, or not listening to providers. How can we get more information to guardians so they know the changes with the federal rules.</i> <i>• I can't but think of how these ideas may have unintended negative consequences for the people we support.</i> <i>• I am seeing a vision that is one size fits all. My person is severely ID</i>
STATE RESPONSE	<p>Education on the transition plans, the new standards, and the provider service changes required under the new rules will need to occur at multiple levels. The state will need the help of providers and case managers to get the information to participants, family members and guardians.</p> <p>The intent of the rules is positive though, and should not result in negative consequences to any HCBS waiver recipient. For this initial phase, the public was invited to forums and explore information posted on the Division's website through a newsletter mailing and newspaper ads. We also sent out emails on our listserv to deliver the information and ask for comments. We will continue to try delivering information in a variety of media platforms, such as our YouTube recordings.</p>
COMMENTS RECEIVED	<p><i>Task Force, Submission Timeline and Requirements for submission</i></p> <ul style="list-style-type: none"> <i>• This Citizen Task Force – Where are they from?</i> <i>• Is this a plan to have a plan? Is this a draft 5 Year Plan?</i> <i>• What is done with the guardian's comments? Does the State take this into account?</i> <i>• If no amendments to the waivers can be approved until the 5 year transition plan is approved, when will we submit it and what is our timeline?</i> <i>• Has CMS provided a timeline for when they will give agency approval?</i>
STATE RESPONSE	<p>The task force has members from multiple roles within the waiver system from all over the state, including participants, parents, case managers, large and small providers from different waivers, advocacy organizations, and state agency representatives.</p> <p>Originally, Wyoming did come up with a "plan for a transition plan" through consultation with our federal partners. As all states learned the CMS expectations for a transition plan, we made changes to it and added more details. The comments submitted have impacted the final draft of the transition plan and the state made some changes. We will submit the transition plans in November. CMS has 90 days to approve. We are hoping to be approved by January or in January, but it will be based on their timeline.</p>
TOPIC	Settings that are Not Home and Community-Based
COMMENTS RECEIVED	<p><i>Concerns about Institutions</i></p> <ul style="list-style-type: none"> <i>• Related to communities – how is it related to state institutions?</i> <i>• If their moving from Institutions to Community, why do we still have State Institutions?</i> <i>• Facilities require professional educated trained individuals – Why is their judgment evaluated at so many different distant levels by disconnected people. It gets removed farther and farther from the individual.</i>
STATE RESPONSE	<p>These new rules only apply to home and community based settings. No institutional services fall within the scope of these rules. The institutions around the country are downsizing, but not everyone is moving out due to several reasons. However, since the institutional model still exists, these rules ensure that services to Medicaid recipients under HCB programs looks and feel different that the services received at institutions.</p>

TOPIC	Settings that are Presumed to have the Qualities of an Institution and “heightened scrutiny” processes
COMMENTS RECEIVED	<p>Concerns with presumptively non-HCB criteria and process</p> <ul style="list-style-type: none"> • <i>Who do we anticipate will do the presumptively non home?</i> • <i>How much control will the State have with Heightened Scrutiny?</i> • <i>Heightened Scrutiny sounds confrontational like The Inquisition</i> • <i>The culture of negativity fostered within the Plan, the use of terminology such as “heightened scrutiny,” seems adversarial and counter to what is needed to achieve successful outcomes for participants and providers.</i> • <i>What will we do with our campus?</i> • <i>My final comment is the area which I have the greatest concern. On page twelve of the transition document under Preliminary Results of Provider Settings I would draw your attention to bullet five [Presumptively non-HCBS]. Back in March when this rule was released I read with great relief that the CMS rule actually provides provisions for states to submit to the HHS Secretary justification/evidence for settings which are presumptively out of compliance and seek waivers for those settings. I am quite surprised that the Department of Health has not presented a process which they will apply for this exception on behalf of providers who have developed safe and affordable housing for the people they serve. My impression is that CMS recognizes that which the “physical” structure may not comply with the standards that a state could make a reasonable argument that it is in the best interest of the system (participants, families, and providers) that certain settings should be allowed to continue. I would argue that the Department of Health has made zero effort, at least publicly, in addressing this possibility. An example of this is the fifth bullet of page 12 where the Department of Health states that 0 settings are being considered for exceptions. I would ask that the Department of Health publicly state if they intend to seek any exceptions to these standards and if so, what the factors/criteria will be to determine if an exception will be presented. Providers, such as NOWCAP Services, have currently just shy of \$3 million dollars in long-term debt developing safe, affordable housing. Some property can be used commercially to service that debt but approximately 2/3 of that cannot be. If an exception is not granted or funds provided to assist in paying off that debt then our organization will face severe financial hardship. If the Department of Health does not intend to ask for exceptions I would request that a rationale as to why be provided so that all parties involved may take whatever prudent and appropriate action is necessary.</i>
STATE RESPONSE	<p>The Division did not intend to have a large number of settings fall under the category of noncompliance. The initial settings analysis did use location information for industrial zones or locations that are over 2 miles from a community area as a setting that will not be in compliance. The discussion to include those areas as “non-compliant” came from a review of CMS guidance on questions to evaluate for settings and a discussion with task force members and state staff on settings where people can safely walk in the neighborhood, access other nearby businesses, have visitors from the general public, and have transportation options to access the community when they want.</p> <p>Based on the comments received, we have modified the settings analysis to eliminate ruling out a setting due to an industrial park or commercial zoning location. They will either be in the “do not comply without modifications” or the “presumed non-HCBS but we will submit evidence to ask for approval.” Wyoming’s transition plan outlines a process of assessment that will be based on examining the characteristics of HCBs rather than relying solely on location, size, physical structure, or geography. Compliance will be determined based on the opportunities and experiences of the members receiving HCBs, according to the standards set in the federal regulation, including but not limited to whether the individual has selected the setting from all available choices; whether the individual’s rights to privacy, dignity and respect, and freedom from coercion are protected; whether the individual has choice in services and providers; whether the setting is integrated in and facilitates the individuals access to the greater community; whether the person has a choice of</p>

roommates, has freedom to control their own schedules and activities, and may have visitors and access to food at any time.

The Division will work with providers and conduct other analysis from stakeholder surveys, state onsite surveys, representative sample case reviews, case management quarterly information and interviews with participants and guardians in order to submit evidence to CMS for the heightened scrutiny process, for those settings that fall into this category.

**COMMENTS
RECEIVED**

Housing concerns

- *Housing. In case the Department of Health is not aware many providers have spent millions of dollars developing housing options for people they support because housing in Wyoming is scarce, unaffordable and in some case unacceptable in quality. Admittedly, several of our housing options do not meet the CMS regulations because of one reason or another. However, all of the options are safe, clean, affordable and available to persons we support. When you add additional service requirements such as specific physical considerations such as roll-in showers, accessible bathrooms, etc... the options for people in that category are nearly zero. Even without those specific requirements the cost for a participant to live in a setting that fully meets the standards proposed is beyond the financial means of the participants who choose to live in our settings. To provide you with an example: our organization owns an apartment building which we provide housing to participants and according to our long-standing practice we charge a participant 1/3 of their income in rent. There is another building less than 5 blocks away built the same year using the same design and dimensions. The current market rent for that apartment setting is \$650 per month for a one bedroom and \$800 per month for a two bedroom. The highest rent we charge for a one bedroom is \$311 per month and \$584 for a two bedroom (total paid by both tenants). Also, as of today the waiting list for Section 8 housing vouchers sits at just slightly more than 800.*
- *In parts of Wyoming including Cheyenne, there is not enough housing for individuals. And if it is available, it is not affordable. The public housing available will have the same type of population so are we just shifting our folks from small homes to much larger segregated communities?*
- *HUD and CMS – HUD rules clearly say that homes already in place are not required to meet the requirements. Is the problem between CMS and HUD?*

**STATE
RESPONSE**

The federal regulation does not prohibit providers from owning housing, nor does it prohibit persons receiving HCBS from living in provider owned housing. In Wyoming, affordable and accessible housing for persons with disabilities may be difficult to find. Some providers have attempted to fill this void by purchasing housing for the use of the people they serve. This practice has permitted many people to live in the community who otherwise could only have been served in an institutional setting, and the Division supports the provider community for their efforts in this area. With the new rules, participants living in these settings should have access to more integration with others who do not have disabilities and receive more options to explore living in more integrated settings according to their choices and personal resources. The Task Force worked on the idea of breaking down some segregation practices by setting a standard that settings should become integrated. However, the public comment received implies this state requirement is more prescriptive than the federal requirement, so the state is changing this standard.

The standards in the new rules specify housing that is specific to one type of disability or one population is a characteristic that has the effect of isolating people, therefore the HUD housing arrangements are an indicator of non-HCBS. Providers should examine ways to integrate their residents with people who do not have disabilities, which may be done in a variety of ways. The provider may bring a more integrated population into an apartment structure and focus on ways to support and encourage more integration with the community in meaningful, more individualized ways than in larger group outings.

The regulation does set out some extra requirements that must be met when an individual receiving HCBS lives in a provider owned or controlled setting, in order to ensure that the setting does not have

institutional qualities and that individuals rights are not unduly restricted. Requirements include:

- A lease should be in place to provide the same protections from eviction as all tenants under landlord tenant law of state or local government. If tenant laws do not apply, a lease or written residency agreement must provide protections to address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law
- Each individual has privacy in their sleeping or living unit
- Units have lockable entrance doors, with the individual and appropriate staff having keys to doors as needed
- Individuals sharing units have a choice of roommates
- Individuals have freedom to furnish and decorate within the lease/agreement
- Individuals have freedom and support to control their schedules and activities and have access to food any time
- Individuals may have visitors at any time
- The setting is physically accessible to the individual

TOPIC

Settings that may isolate or segregate people from the broader community

Industrial or Commercial Zoning Restriction concerns

- *Programs located in industrial parks will no longer be allowed. If a person is accessing the community during the day what difference does it matter where they start the day? Are rules going to be changed requiring services to be given outside the residence?*
- *Kind of twisted standards... People not on the Waivers live next to an Industrial Park? Where in the CMS rules does it state that Day Services cannot be provided in an Industrial Park?*
- *Zoning issues are best left to the City. This is Federal interference*
- *Do the Feds think we just throw our participants into a hole?*
- *Define Industrial Park*
- *Zoning is a city function. Not a State or Federal function.*
- *The reference to no industrial/commercial park reference is outside of CMS and BHD control. This is done on a city level by planning and zoning officials and other local officials and the people of the individual communities. Again one size does not fit all.*
- *Zoning issues regarding setting placement are the responsibility of the city the provider is located within, not CMS or BHD. Industrial park locations do not necessarily equate to an isolated experience or an undesirable location for service delivery. If providers are required to move from their current location, who will fund such a monumental change? What will happen with participants if the provider cannot comply?*
- *We would ask that the State refrain from adding stricter, more prohibitive rules in addition to what the federal regulations already require. For example, the state rules state that services may not be offered in industrial parks. This is not mentioned in the federal regulations.*
- *Can't put day services into a Commercial or Industrial Zone? Where should they go? What are we doing with Participants?*
- *Bridges and MRSI both are using repurposed buildings. When the Bowling Alley was converted everyone else moved in. MRSI has relationships with the businesses around our facility.*
- *Need exception built into the plan that includes common sense*
- *An industrial park may not be isolating. In Evanston, industrial areas are adjacent to (across the street from or next to) residences. The industrial area where MRSI is located is 2 minutes away from commercial areas. Some of our participants can walk home to their residential area, as they are basically 2 blocks away. Emphasis should be on working to involve participants in the community rather than eliminating existing sites. The MRSI building is a great space that could be used to offer participant and community classes, etc. Sites could work toward more variety and diversity rather than being replaced.*
- *If the Day Services keeps allowing services in the participant's residence, this is the only way*

COMMENTS
RECEIVED

**STATE
RESPONSE**

Based on the comments received, we have modified the settings analysis to eliminate ruling out a setting due to an industrial park or commercial zoning location. They will either be in the “do not comply without modifications” or the “presumed non-HCBS but we will submit evidence to ask for approval.” Wyoming’s transition plan outlines a process of assessment that will be based on examining the characteristics of HCBS rather than relying solely on location, size, physical structure, or geography. Compliance will be determined based on the opportunities and experiences of the members receiving HCBS, according to the standards set in the federal regulation, including but not limited to whether the individual has selected the setting from all available choices; whether the individual’s rights to privacy, dignity and respect, and freedom from coercion are protected; whether the individual has choice in services and providers; whether the setting is integrated in and facilitates the individuals access to the greater community; whether the person has a choice of roommates, has freedom to control their own schedules and activities, and may have visitors and access to food at any time.

**COMMENTS
RECEIVED*****Concerns with the standards for “Isolation”***

- *What is the standard for “isolating individuals?”*
- *Persons should be able to have services provided where other facilities that serve people with disabilities are located, as long as other types of activities occur in the area, as well.*
- *Define isolation. Where would participants go? Are services isolating?*
- *Further guidance is needed to determine what the term “a setting just for people with disabilities” means. There are many settings in our communities that have specific purposes. This item could severely limit the ability of waiver participants to receive the services they require.*

**STATE
RESPONSE**

As more CMS guidance is released for non-residential settings, the state will rely on the federal regulation and the accompanying guidance issued by CMS to define and explain these terms. In developing these aspects of the regulation, CMS considered the qualities most often articulated by persons with disabilities as key determinants of independence and community integration, which includes that the setting:

- Supports full access to the greater community to the same degree as individuals not receiving Medicaid HCBS.
- Is selected by the individual from options including non-disability specific settings.
- Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
- Optimizes individual independence in making life choices including daily activities, physical environment, and with whom to interact.
- Facilitates individual choice regarding services and supports, and who provides them.

CMS released guidance documents that are useful in understanding the regulation. Documents that may be of particular interest to HCBS providers would include “*Regulatory Requirements for Home and Community-Based Settings*” and “*Guidance On Settings That Have The Effect Of Isolating Individuals Receiving HCBS From The Broader Community*”. Based on public comment received on restricting industrial or commercial zones, the Division changed the state standards to eliminate a flag solely on the basis of zoning. The settings will be analyzed for compliance or non-compliance if evidence is found for a combination of indicators, as specified in this part of the new rules:

- The setting is designed specifically for people with disabilities, and often even for people with a certain type of disability.
- The individuals in the setting are primarily or exclusively people with disabilities and on-site staff provides many services to them.
- The setting is designed to provide people with disabilities multiple types of services and activities on-site, including housing, day services, medical, behavioral and therapeutic services, and/or social and recreational activities.
- People in the setting have limited, if any, interaction with the broader community.

- Settings that use/authorize interventions/restrictions that are used in institutional settings or are deemed unacceptable in Medicaid institutional settings (e.g. seclusion).

For the full text of the federal regulation and all of the associated guidance, please visit <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html>

TOPIC Settings that may isolate or segregate people from the broader community

Integration and Access Issues

- *Do the restrictions apply to the classes – integrated into classes?*
- *We need to be sure that we are not providing fewer services to our participants – how is that going to happen?*
- *Sister needs lots of care – how is that affected by this?*
- *Staff takes participants out into the community*
- *Doesn't time with staff count as integration?*
- *What is the point of hiring highly educated, experienced people to serve in our communities 'Facilities'? Their programs can no longer be individualized; their training & programs are evaluated at levels too far removed from the implementation*
- *Please be open to the experiences that people are having in any given setting. The setting itself is much less important than what occurs within in the setting. If the experience that occurs in a setting is promoting integration, or teaching skills that will assist a person in living a more typical life, then the setting in which the experience is transpiring becomes less significant. Requiring a provider to rent space (community integrated) rather than utilizing existing provider owned space is a change in geography, but doesn't necessarily ensure that the activity is meaningful. It can also add expense to an already underfunded system.*
- *Segregation is not just geographical, but attitudinal as well. It could be more detrimental to require people to complete activities in a "community" setting just because it is considered integrated. People should be able to access the library or recreation center to browse books or exercise. However, expecting all activities to take place in these types of setting is atypical (I attend class in a classroom...not the community room at the library), Atypical situations single people out and can lead to folks being a spectacle rather than valued community members. Please be aware of unintended consequences associated with integration. We are not just changing a system...we are changing a society and it's perception of people with disabilities.*

COMMENTS
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Evaluating a setting's compliance with the new standards involves looking at geography, whether the setting is not-integrated with people who do not have disabilities, the options the person is given, and the experience of the person receiving services. Integration is difficult to measure because it is not just the number of outings a person goes on, the types of outings or size of group that goes out. The state understands that integration and segregation is "attitudinal" and can differ based on one's personal experiences. The different questions in the surveys and the other data that will be analyzed from case management reports and case reviews will evaluate all of these factors.

STATE
RESPONSE

What we have specifically in the new rules is that the participant should receive services "in a location among other private residences and retail businesses, in an area with consistent traffic patterns and where visitors are present and visiting regularly". So besides geography, the state will take a person's "experiences" into account as part of the setting analysis. These other "location" and "segregation" characteristics must also be factored in, but alone, will not determine a place to be out of compliance. Services should support a person access the great community and optimize independence and choice. Services in a congregate setting that does not have regular access to the general community and people without disabilities is an indicator of "isolation" and non-HCBS.

As stated in the previous response, CMS considered the qualities most often articulated by persons

	<p>with disabilities as key determinants of independence and community integration, which includes that the setting:</p> <ul style="list-style-type: none"> • Supports full access to the greater community to the same degree as individuals not receiving Medicaid HCBS. • Is selected by the individual from options including non-disability specific settings. • Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint. • Optimizes individual independence in making life choices including daily activities, physical environment, and with whom to interact. • Facilitates individual choice regarding services and supports, and who provides them. <p>When we analyze settings for compliance with the new regulations, we need to have evidence from the provider that an individual's experience in the setting meet the bullets listed above or the provider will need to make modifications to their practices to meet and maintain compliance.</p>
COMMENTS RECEIVED	<p><i>HIPAA Concerns with integration</i></p> <ul style="list-style-type: none"> • <i>How can providers be so broad in their scope that they do not cater to individuals with a certain type of disability but instead provide services for the general public as well. The setting should not be segregated from people receiving services without disabilities—but what adult without disabilities needs Day Care. How can providers ensure that HIPAA is being adhered to if the public has so much access to a Care Center that everyone knows who participates in what Medicaid program.</i> • <i>There are HIPPA implications</i> • <i>I would also like to address Adult Day Services settings. The new rules call for basically a disassembling of these programs. First of all, to allow the public to come in and mingle at will is ridiculous. When did HIPPA become a non-issue? We have worked hard to ensure that our participants names, whereabouts, everyday dealings, etc. remained confidential to the extent that our participants (who are people too) choose them to be, out of the requirements of HIPPA, and respect for the person. This is a client right: "I have a right to confidentiality of my personal information and records. A. Controlled access to my personal information and medical records is outlined in Chapter 45 Provider Certification and Sanctions and in HIPPA regulations. B. Information about me shall not be released to persons who have no legal right to it. C. Emergency personnel may have access to critical information about me due to health and safety matters."</i> • <i>Mandating settings not just for people with disabilities and unfettered access by visitors raises privacy and HIPAA concerns.</i>
STATE RESPONSE	<p>In regard to HIPAA concerns, participants should not wear identifying badges or logos on their person. This is a part of the new rule requirement specified in guidance posted by CMS. Requiring participants to show they are part of a program or facility when they are in the community has the effect of separating them from the general public and is a practice that needs to stop. Addressing any safety issues with a person in the public should be addressed in a manner more inconspicuous so the person or group feels more included in the area of the public in which they are frequenting. However, providers should find ways to integrate participants into public settings based on interests, clubs, activities, or volunteer activities without the fear of violating HIPAA. The privacy rules are not in place to keep people from being fully integrated and involved in the community. The Division will work with providers on sharing new ideas, best practices from other providers that will increase meaningful integration around Wyoming.</p>
COMMENTS RECEIVED	<p><i>Questions regarding how to integrate people</i></p> <ul style="list-style-type: none"> • <i>How are providers to offer services for/incorporate those without disabilities into activities?</i> • <i>Would like to see examples of where this is working</i> • <i>Need more examples of providers using this model, lease buildings, No more Adult Day services,</i>

	<p><i>and Community Centered activities</i></p> <ul style="list-style-type: none"> • <i>If the intent is the elimination of day facilities and thus relocating the bulk of services to a participant's home, how does that avoid isolation? How would this model promote a regular lifestyle for individuals who do not have full-time employment and end up spending the majority of waking hours in their home?</i> • <i>How are providers supposed to entice people without disabilities or a certain type of disability into their programs?</i>
STATE RESPONSE	<p>CMS states the participant should receive services “in a location among other private residences and retail businesses, in an area with consistent traffic patterns and where visitors are present and visiting regularly”. The state will take a person’s “experiences” into account as part of the setting analysis. These other “location” and “segregation” characteristics must also be factored in, but alone, will not determine a place to be out of compliance.</p> <p>Some providers in Wyoming and around the country have experimented and found success with different ways of providing services without using a provider operated facility. They use other facilities that are also used by the general public. Some providers also base services out of where the person lives and plan their day in the community from a “home-base” rather than a day facility.</p> <p>One parent provided comment at a forum that he has a model cheaper than the state institution and provider operated homes, which is a home very inclusive within the Jackson community. Three gentlemen who grew up together in school now have a shared condo own by the three men. He discusses how the model is cheaper than large provider-operated homes and leads to a life fully included in the community. There are ways to offer housing and day activity and employment solutions outside of traditional facility approaches. The Division will work with providers and families on hearing about new or different ideas for services and living arrangements so participants can have more options available from which to choose.</p>
COMMENTS RECEIVED	<p><i>Concerns with additional requirements for provider operated settings</i></p> <ul style="list-style-type: none"> • <i>They [participants] need the structure of a schedule, a routine, and the socialization of a group. A job and a place in the community is a wonderful long-term goal but reality is, that isn't always there. They need a place to go during the day, a structured schedule, and lots of advice on daily activities. Allowing access to whatever they want will be overload. I always thought a group home would be like a family home. That would mean meals would be eaten together with everyone in the family eating the same thing at the same time. I've heard the statement I'm not running a diner here. This seems to apply in this situation. I think there needs to be camaraderie and a sense of community, not a disjointed me-only attitude. This schedule and structure does not need to be set in stone and impossible to change. But using a schedule and adjusting to others wishes is a good method of learning to deal with others and life's inconsistencies.</i>
STATE RESPONSE	<p>Under the new rules, participants must have freedom to control their own schedules and activities, have visitors, and access to food at any time. Their services should “optimize one’s initiative, autonomy, and independence in making life choices, in such activities as daily activities, physical environment, and with whom to interact and be included in the development of a schedule that meets one’s wishes and is reflected in person-centered plan.” The rules also specify that the person has the right to participate in unscheduled and scheduled access to the community, can come and go at any time, and not have a regimented routine. Providers and plan of care teams should explore a “person-centered” model to deliver services and be willing to adjust schedules, meals, or agreed upon routines based on a person wanting to change their mind and do something different, eat something different, etc. It does not mean a person won’t ever have a schedule to follow, since a person who has a job will likely need to arrive at a certain time and take scheduled breaks.</p> <p>The rules want participants the same rights afforded to people who don’t have Medicaid HCB services. In a person’s home life in a residential setting, since they are not usually living with “family”</p>

in these settings, the person must be afforded the right to decide when they want to eat, with whom and what they want to eat. When a provider is making these choices for the participants in their care without allowing for individual choice, the service is being “institutional” in their approach rather than HCB. The Division will work with providers on exploring different ways this type of service approach is possible.

**COMMENTS
RECEIVED**

Concerns with possible Non-HCB characteristics of facilities and home sizes

- *I am a parent and guardian of a 41 year old developmentally disabled man. I am also a board of director for NOWCAP Services, a provider of services for the handicapped and mentally disabled in Wyoming.*
 1. *I believe that the requirement for only 3-4 persons in a residential group home is not economically feasible. My son lives in a nice residential area of Rock Springs, in a nice 4000 square foot house that has been remodeled with 8 bedrooms (each client has their own room) for people with disabilities. I understand the economies of scale, and if NOWCAP was forced to have only 4 people in this home, they would have to sell it and move my son and the others to a much lesser house in a much less desirable neighborhood.*
 2. *NOWCAP has a campus in Casper that has buildings for employment, work shops and offices along with several houses. I understand that these homes would be considered “Institutional” under the new guidelines. Again, this is a very nice setting for serving people with disabilities and is only affordable because of “economies of scale”. I believe that the vast majority of the persons being served have a better quality of life than they would if these facilities did not exist. These facilities were built under the existing guidelines and a lot of money was spent to build them.*
- *When reading the summary of proposed changes, one of the changes would require these smaller group homes to house other than those with disabilities. In my opinion this is an unrealistic expectation. My son needs 24 hour supervision and care. I cannot imagine a “normal” person living in that environment.*
- *How do individuals who do not qualify for provider settings get enough money to set up independent living arrangements? Competitive wages, not reliant on SSI (which delivers essentially abject poverty), alternative housing options, budget to allow for individual services when needed.*

**STATE
RESPONSE**

Size considerations do no guarantee quality services, nor do they guarantee integration. As such the focus of the federal regulation and Wyoming’s transition plan is on the member’s experience. This focus includes, but is not limited to, whether the individual has selected the setting from all available choices; whether the individual’s rights to privacy, dignity and respect, and freedom from coercion are protected; whether the individual has choice in services and providers; whether the setting is integrated in and facilitates the individual’s access to the greater community; whether the person has a choice of roommates, has freedom to control their own schedules and activities, and may have visitors and access to food at any time.

Serving people in smaller settings can have greater cost than in congregate settings due to the need for lower staffing ratios (more staff per individual), but there are often greater infrastructure costs with larger congregate settings. Medicaid will continue to pay for HCBS in various settings, so long as the setting meets the new standards.

Some providers in Wyoming and around the country have experimented and found success with different ways of providing services without using a provider operated facility. Participants may share an apartment with other participants and live in an apartment complex where people without disabilities live. Some participants may purchase their own homes like people without disabilities do. During the transition process, the state will work with providers, participants and families on different options for housing so that any barrier that exists can have workable solutions if the participant wants to pursue a more independent and integrated living option.

<p>COMMENTS RECEIVED</p>	<ul style="list-style-type: none"> • <i>Will the State of Wyoming beef up its tenant/landlord laws?</i> • <i>Lockable doors to bedroom and house? Just because this is rule doesn't make it right</i> • <i>Do all participants need to be squeezed into this model?</i> • <i>Don't we have a residential transition plan?</i> • <i>Problem with a key for the bedroom</i> • <i>People who can't pull up their pants can't keep track of a key. My Brother In-Law has no sense of the value of a key. He might play with a plastic key</i> • <i>Lockable doors for all persons served is not safe or reasonable. Again one size does not fit all. There will be exceptions.</i> • <i>Every community already had tenant/landlord protections, landlords just need to introduce leases to those who want them this may come back to bite the consumer/guardian.</i> • <i>All families, guardians, and advocates want the best possible life for their loved one. But there comes a time when reality and common sense needs to be the priority. If they are treated with dignity and respect in all facets of their life we are doing what is just and moral. All the freedoms and rights you are addressing do need to be considered. And I'm sure there are instances where changes need to be made. But one general statement that ALL Medicaid recipients need a lease, freedom to eat as they please, and access to all these choices is not in the best interest of the person needing help. All these choices and possibilities will be confusing and over stimulating for most of them.</i> • <i>Let's talk about roommates and housing. How in the hell do you expect our folks to afford to rent or lease, pay for food, utilities, and phone (and these are just the staples necessary to get along) on the very limited income that they get once a month?! And don't tell me that they will get a job, I will address that shortly. The grand idea of bringing in a roommate is very risky. Did anyone consider the type of people that the roommate may bring to the residence? This would address the rule that the public not only could be, but SHOULD be coming in and out of the home, but again, is this really worth risking the health and safety of our folks? The roommate may be a great person with the willingness and patience and compassion to help one of our folks, but living with a developmental disabled person, and especially one with an accompanying mental illness is a full time job. Would we automatically expect that the roommate would take on this responsibility? If not, how much tolerance is a roommate (or more than one) going to have with staff coming in and out of the home? And for how long? Like it or not, this is what this "new rule" is suggesting, or more like demanding.</i>
<p>STATE RESPONSE</p>	<p>The new rules specifically require that participants have a right to a lease and lockable entrances to their bedroom and home. Locks can involve options other than traditional keys. If a right to one of these items needs to be modified or restricted, the rules state the process required to restrict those rights, which includes:</p>
<p>COMMENTS RECEIVED</p>	<ul style="list-style-type: none"> • <i>Those in rural areas and those that want to live in a group home by choice – how does this fit into this targeted criteria model?</i>
<p>STATE RESPONSE</p>	<p>The rules will allow people to live in homes in rural areas if that is their choice. The setting must comply with the new rules, however. Compliance will be determined based on the opportunities and experiences of the members receiving HCBS, according to the standards set in the federal regulation, including but not limited to whether the individual has selected the setting from all available choices available; whether the individual's rights to privacy, dignity and respect, and freedom from coercion are protected; whether the individual has choice in services and providers; whether the setting is integrated in and facilitates the individuals access to the greater community; whether the person has a choice of roommates, has freedom to control their own schedules and activities, and may have visitors and access to food at any time. The rural nature may be the person's preference, and the rules allow for that. The rules also require that the person have regular access to the broader community based on their preferences.</p>

**COMMENTS
RECEIVED**

- *Choices that are not always the safest or most protected and for which back up plans are implemented to support the person if risky choices do not work out place providers in a precarious and very exposed position with regard to consequences for an unfortunate outcome. What happened to concerns for health and safety?*
- *How to balance health and safety with choice and dignity of risk?*
- *How to balance health and safety with choice?*
- *Again who is going to pay to make providers compliant. The system is already failing with waiver redesigns. Choice is not a choice anymore.*
- *As mentioned in the Plan, a "one size fits all" approach is not the desired outcome. Unfortunately, that is exactly what many of the proposed changes will deliver including loss of existing case managers, mandatory employment, displacement from current day habilitation facility, etc. Proposed changes overlook the varying levels of involvement experienced by participants and fail to address the special needs of behavioral challenged individuals.*
- *Giving a key to the front door of the house to a participant?! Who knows who they will let in or who will end up with the key when they lose it, and believe me, the key will get lost or misplaced. I'm letting CMS and the Division know that, contrary to what we want to believe, most people in this world are not tripping over themselves to help those who need it. All it takes is one bad apple to totally wreck and devastate the life of one of our participants. We have always said that our folks are at risk of exploitation, and we say this for a reason. Because they are!! What if it were your son or daughter that was the exploitation risk? Would this be acceptable, or would you want them protected?*
- *How do we protect people who have been abused?*
- *I am very upset about the proposed changes in the 5-year transition plan. I agree that our folks also deserve and have a right to the freedom's that anyone not on Medicaid does, however, it seems that health and safety has been put aside. The Division has ALWAYS maintained high standards and put the health and safety of our participants first, however, these changes are inconsiderate and destructive to those that we have so strongly advocated for. What has the Division done to advocate for our participant's in the face of CMS? Has anyone from the Division voiced an opinion to CMS that these new "rules" would absolutely harm, not all, but several of our folks? Does the Division agree with these changes, and if not, have you been yelling and screaming for the health and safety of those who count on us for that? This one size fits all approach is not only absurd, it is ignorant and unrealistic!*

**STATE
RESPONSE**

The new rules protect the rights of a participant to exercise informed choice. They can choose the living environment, services, providers and types of supports based on one's needs and preferences; optimize one's initiative, autonomy, and independence in making life choices, in such activities as daily activities, physical environment, and with whom to interact; design a schedule that meets one's wishes in the person-centered plan; and participate in unscheduled and scheduled access to the community, come and go at any time, and not have a regimented routine. With these standards, a person can design a plan full of activities and opportunities and still make plans for health and safety concerns by utilizing back up plans and other risk mitigations.

There is still the requirement for teams to develop back up plans and discuss the risks associated with the person's choices, but the threat of risk should not be a reason that a person is denied choice. A person-centered model balances the dignity of risk in exercising self-determination, and encourages the person's team to explore ways to support the person and provide for back up plans in case a choice leads to a negative experience. For rights that must be restricted the team must follow the requirements of the new rule.

Regarding the employment concern, participants need supports to access and keep employment under the new standards, but we are not saying employment is mandatory. Our goal is to get everyone of working age employed, but there may be some people who choose otherwise or have difficulty finding employment.

<p>COMMENTS RECEIVED</p>	<ul style="list-style-type: none"> <i>We should consider what I think are probable OUTCOMES of participants having much more say in who they live with:</i> <ol style="list-style-type: none"> <i>There will likely be a decrease in housemates fighting and less restrictions and restraints from implementing behavior crisis plans which could spill over to day services as well.</i> <i>Although this concept creates a nightmare in large settings, it seems it is much simpler for smaller settings, reinforcing the desire to transition to smaller settings; the direction we are going anyway;</i> <i>Participants who choose with whom to live will likely choose others they have things in common with, therefore will likely be interested in many of the same outings and integrated activities which alleviates some of the heartburn providers are having over how to manage staffing for individual activities.</i>
<p>STATE RESPONSE</p>	<p>The state agrees. Honoring and encouraging participants choice in living arrangement and choice in roommate will likely lead to people choosing other people they like to be around and decrease some of the behaviors or issues that occur when people live in congregate settings.</p>
<p>COMMENTS RECEIVED</p>	<ul style="list-style-type: none"> <i>Unscheduled access to the community may be unrealistic in towns with no public transportation or taxi service that could be cost prohibitive to the participant. For participants who need assistance, unscheduled access will require an on-demand staff. How would this be funded?</i> <i>This will require more staff to allow clients to go do what they want whenever they want.</i> <i>Because of the staffing ratio how do we individualize for all Participants?</i> <i>This will require more staff as someone will have to available to cook or take someone out to eat when they want.</i> <i>Having access to different activities again is unsustainable. You would have to public transportation, which most small communities do not have and staff available 1 to 1 to answer each persons whim. That does not happen in any families in the community. So is CMS and the State again making these community residence different that other single family residences?</i> <i>Goals and approach cannot be argued, but it is going to take a lot of money, CMS won't help, the legislature won't help, so what happens if the lack of funding prevents us from achieving these goals?</i> <i>Would the words 'integrated as much as possible' help?</i> <i>A lot of Waiver Programs are more integrated into the community than families who are not on the Waiver</i> <i>Do we [the state] have friends who have disabilities? Is that our philosophy? More natural supports. Natural supports is not even in the mission for State employees of the Department of Health. BHD employee's do not have any skin in the game. Whatever happened to leading by example?</i> <i>Some of these requirements seem like they are limiting choices of Participants.</i> <i>What happens to choice if an individual wants to spend time with like individuals?</i> <i>It may be unrealistic to assume every participant will be befriended by someone without a disability.</i> <i>Also, on a side note, I just want to point out that like-minded people relate to each other. It is this like mindedness that allows us to be comfortable in our environment, to feel safe and that we are an asset in the setting. No one in any program, participants or staff, are better or worse than each other. Did CMS or the Division consider that Day Service settings that are structured around the quality of life of our folks, based on their needs, are part of what give their life meaning and purpose? If CMS or the Division feels that our folks are being isolated and are not being treated equal to those that are not receiving Medicaid services, it is only because they have created that perception. I get up and go to work each morning, my</i>

	<p><i>participants get up and come into the center. What is the difference?</i></p> <ul style="list-style-type: none"> <i>It seems that a persons' schedule is only OK for the person to choose if they want to be "in the community." What if they do not want to be "in the community." Much higher funding is necessary to be able to accommodate what everyone wants to do at the same time.</i> <i>Community access: What are they comparing this to?</i> <i>What is the control group?</i> <i>What amount of Community access is appropriate for someone with a monthly income of \$700.00?</i> <i>Without guidelines to this will require us to add more staff to accommodate this requirement.</i> <i>It takes years to unlearn those behaviors</i> <i>Making transition will be critical. Changing culture will be difficult.</i>
STATE RESPONSE	<p>The regulation ensures that individuals receiving HCBS are given opportunities for, and provided with access to the larger community. The regulation <u>does not</u> require individuals to participate in activities in the community to an extent greater than the individual chooses. The service setting must support and optimize a person's access to the broader community, for which the provider must provide evidence that they do this for the setting to meet compliance with these standards. The number of outings will not be enough evidence when looking at the individual's "experiences" and the way a provider supports and optimizes access, choice, and individual autonomy.</p> <p>Staffing support and transportation services provided to honor a participant's choices and changing schedules may need to change to fully implement practices that comply with the new regulations. The Division plans to inform all stakeholders, including providers, participants, guardians, legislators, and advocacy groups about the regulations and the state's transition plans so we can work together on funding concerns, the structure and rates of services, and how we can measure the outcomes in which the rules are envisioning. However, the community integration does not require 1:1 supports. Other approaches may work as well. Once again, the way the service is delivered will matter more.</p> <p>The Division agrees that these changes will be a culture shift in many ways. People in the community must be a part of the solution to integration and inclusion and overcoming barriers to accessing activities and building more meaningful relationships with others outside of the HCB service system.</p>
COMMENTS RECEIVED	<p><i>Concerns with access to food, non-regimented schedules, visitors</i></p> <ul style="list-style-type: none"> <i>If an individual can access food at any time and eat when and what they want to, have a non-regimented day, have non-disabled roommates, visits by others at any time of the day etc...WHY ARE THEY IN A GROUP HOME????</i> <i>Conflicting messages being give. Individuals can come and go when they want to and don't need to follow any schedule then why are we required to have a certain amount of staff present to supervise them. One is in a group home because they cannot function on their own, otherwise if they can do these things they don't need a group home.</i> <i>Routine and consistency are the key ingredients for a successful life for an individual with an ID. Do away with these fundamental attributes and you have a recipe for failure.</i> <i>The requirement for unscheduled community access will result in hardship to providers unless additional funds are available to assist with providing the support needed. Most people on the waivers do not have transportation available and public transportation availability is severely limited. Providers will need to provide this transportation when requested.</i>
STATE RESPONSE	<p>The new standards uphold the person's right to exercise informed choice, specifically, one must be able to choose the living environment, services, providers and types of supports based on one's needs and preferences, have services that optimize one's initiative, autonomy, and independence in making life choices, be able to design a schedule that meets one's wishes and is reflected in person-</p>

centered plan, have access to their food when they want, and participate in unscheduled and scheduled access to the community, come and go at any time, and not have a regimented routine. The rules do not give them rights to eat other people's food. These standards will require a change in the approach used by some providers when providing services in order to comply with the new rules. Participants need to receive individualized services based on person-centered planning that reflects the person's needs and preferences. If the services provided are individualized, then the routine and schedule chosen by the participant may be acceptable with the new rules, as long as the person's rights are protected and rights restrictions are modified according to the new rules.

For a participant who has a need for one of the rights to be restricted, the person's team must make decisions based on that person's assessed need for a restriction and not base a decision solely on a diagnosis, medical condition or a possible behavior that happens on occasion. The rules specify that any modification or restriction of the additional conditions, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:

- (1) Identify a specific and individualized assessed need.
 - (2) Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
 - (3) Document less intrusive methods of meeting the need that have been tried but did not work.
 - (4) Include a clear description of the condition that is directly proportionate to the specific assessed need.
 - (5) Include regular collection and review of data to measure the ongoing effectiveness of the modification.
 - (6) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
 - (7) Include the informed consent of the individual.
 - (8) Include an assurance that interventions and supports will cause no harm to the individual.
- Any health and safety concerns must be based on assessed needs of the person and not general fears or concerns because of the person's diagnosis or disability. The plan of care must address these issues specifically and in the manner specified above.

COMMENTS RECEIVED

Concerns with how to follow new rules with current state requirements

- *The current rules require a regimented day in order to bill for those services. Are billing requirements going to be altered to meet this new expectation?*
- *It seems that the needs of people with severe behavioral issues or severe mental illness are disregarded in the CMS and state plan. Perhaps a separate fund of state money needs to be available for some programs to help these participants who are able to be in a community program if there is a high amount of structure and coordination (some institutional qualities) without needing to be in an institution.*
- *What are we to do with the individuals who require 24 hour supervision? Are we going to fill up WLRC and the WSH with individuals who cannot live on their own without any structure? This one size fits all approach shows a lack of understanding on the part of this administration. Also neither WLRC nor the WSH can handle this population according to their own administrators.*

STATE RESPONSE

The state's requirement for schedules to document service delivery does not require "regimented days". The schedules should always be individualized for the person and can be somewhat "open-ended" in the template so activities that are unplanned can be documented. The flexibility of the 15 minute units for most services also allows a person to have a non-regimented day that is customized to the person's needs and preferences.

The new regulations, *Olmstead*, and the ADA afford participants with mental illness to receive home and community based services. Therefore, the new rules apply to this population and the state must ensure the settings meet compliance for this population just like any other. Those with behavioral

	<p>support needs must receive services customized according to their preferences and needs as well, which means that some may choose and “need” structured or routine activities, while others can handle less structure and may prefer more autonomy to choose other services and supports. The provider must comply with the new standards if serving people with intensive behavioral support needs. If any of the rights must be modified based on an individual’s need, the need must not be based solely on the person’s diagnosis. The provider must follow the new standards for modifications to rights, which are found in under § 441.301(c)(4)(vi)(A) through (D).</p>
COMMENTS RECEIVED	<p><i>Assistive Technology</i></p> <ul style="list-style-type: none"> <i>The new requirements seem to emphasize independence. For those with an AAC device needed for communicating, will independence training include communication methods such as AAC?</i>
STATE RESPONSE	<p>The new federal standards focus on outcomes and experiences of individuals and the state standards focus on some of the processes we should use to ensure an individual “experiences” independence as much as they can. The requirement for ongoing habilitation training should include the use of assistive technology to communicate and the waivers have services that can cover communication device purchases and maintenance if no other party is available to pay for the item or service.</p>
COMMENTS RECEIVED	<p><i>Complicated process to modify/restrict rights</i></p> <ul style="list-style-type: none"> <i>At what point do Doctor’s orders take precedence?</i> <i>This is a paperwork boondoggle</i> <i>Someone not from Wyoming is making blanket decisions</i>
STATE RESPONSE	<p>The regulation ensures that individuals receiving HCBS are given opportunities for, and provided with access to the larger community. The regulation does not require individuals to participate in activities in the community to an extent greater than the individual chooses. The rules specify that any modification or restriction of the additional conditions, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:</p> <ol style="list-style-type: none"> (1) Identify a specific and individualized assessed need. (2) Document the positive interventions and supports used prior to any modifications to the person-centered service plan. (3) Document less intrusive methods of meeting the need that have been tried but did not work. (4) Include a clear description of the condition that is directly proportionate to the specific assessed need. (5) Include regular collection and review of data to measure the ongoing effectiveness of the modification. (6) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated. (7) Include the informed consent of the individual. (8) Include an assurance that interventions and supports will cause no harm to the individual.
COMMENTS RECEIVED	<p><i>Concerns with the role of Guardians in the Protection of a Person’s Rights</i></p> <ul style="list-style-type: none"> <i>The Court states that the guardianship is full and complete. What if the guardian does not want this change?</i> <i>Wouldn’t the new freedoms make it harder for guardian to let their child go?</i> <i>First and foremost, I strongly disagree that our Guardian’s advocacy will not carry the same weight as it has in the past. When this is taken away from the Guardian, you are giving the provider’s the authority to make certain decisions for our folks. And what are those decisions going to be based on? On what someone who thinks they know what’s best for someone? It seems to me that usually the Guardian knows</i>

	<p><i>what's best for their ward, and they know when to trust the participant's team because they know in the end they have a choice. CMS and the Division better think long and hard before taking advocacy rights away from the family members/Guardians, or even telling them that their opinion doesn't matter and will not be considered. What if you were the Guardian? Would this really be ok for you?</i></p>
STATE RESPONSE	<p>The rules are meant to give specific protections to a participant's rights, which must also be protected and supported through guardianship, if applicable. A person is entitled to the rights even if he or she has a guardian. The right to informed choice may need to go through the guardian for approval, but the participant still has the right to participate in developing their plan of care, choosing activities, food, visitors. The guardian should be fully involved to know their ward's preferences in order to honor them and act on their behalf. The new rules still require the informed consent of the guardian if one is in place. The state monitors and reviews guardianship papers to ensure that the guardian is only acting on the ward's behalf in the areas specified in the court documents.</p>
COMMENTS RECEIVED	<p><i>Issues with Requiring Support To Work In A Competitive, Integrated Setting</i></p> <ul style="list-style-type: none"> <i>Unrealistic expectations and conflicting messages are interwoven in this entire plan. On one hand you advocate for autonomy and then require things such as working or vocational training? Requiring staffing numbers and yet freedom to go and come when you want to go with no schedules or expectations. You cannot have it both ways.</i> <i>How do you get employers to allow Participants to volunteer or work?</i> <i>What does isolation mean if someone wants to work on a rural ranch?</i> <i>What if some people don't want to work. How do you get Participants and family members to allow a person to work?</i> <i>In presentation on April 23, 2013 by Nancy Thaler, she stated there will be a staff storage in the near future but the proposed transition plan will require more staff.</i> <i>Everyone with an ID is required to work, yet the entire population only employs around 70%. Not only is this faulty logic, but unrealistic. Some individuals cannot work or do not want to work. Maybe for those who choose not to work, their SSA checks can be stopped to give them an incentive to work? And how does one prepare an individual to work if they can opt out of any schedule?</i> <i>Employment for every participant is an admirable goal, but realistically, placement is dictated by the economic climate of each community and willingness of employers to hire individuals who are only able to work very part-time hours. Additionally, some participants have no interest in working. Will their ability to choose not to work be removed from the equation?</i> <i>There is currently no standard definition of "integrated community employment setting". This needs to be defined and all state agencies be in agreement as to what this requirement means.</i> <i>Employment: Some of the folks on my caseload believe that coming into the center is their job. Some of my folks don't want to get a job and are doing what they determine is their purpose in life, or what they are choosing to do with their life. Some of my folks are focusing on becoming behaviorally and emotionally stable so that they may become a valuable employee. Some of my folks are incapable of holding a job, and some of my folks are not hireable due to their limited capabilities. Who made it CMS's or the Divisions job to determine that everyone should have a job? I say leave the employment decision to the individual. We are dealing with individuals, right? Real people with real voices?</i> <i>Many people in our communities choose not to work. Again, where is the choice factor?</i>
STATE RESPONSE	<p>If the individual is receiving HCBS services and supports in the work setting, they will need to have choices to the same extent as others working in the same setting who are not receiving HCBS. The federal regulation says that full access to the greater community includes "opportunities to seek employment and work in competitive integrated settings". That does not mean that all persons receiving HCBS must work in the community, but that an individual should have the opportunity to do so if that is what the person chooses.</p>

Neither the federal regulation nor Wyoming's transition plan state that it is wrong for individuals with disabilities to spend time at a place that serves other people with disabilities. However, the regulation does clearly specify that integration refers to the greater community and not solely a community of one's peers. Individuals receiving HCBS must have the choice and opportunity to access the greater community.

The state disagrees that integrated employment is not attainable by all persons with disabilities who desire to work in the community; with the right supports, community employment can be achieved. The state is still waiting on additional guidance from CMS on employment and day program services. Based on information from national calls and webinars, we expect that the guidance will be similar to the guidance provided for residential settings in emphasizing self-determination, assuring access to and opportunities for community inclusion, facilitating member choice, and ensuring that rights are not unduly restricted.

**COMMENTS
RECEIVED**

Concerns with "Access to food"

- *What happens if an individual who eats all of their food and their roommates food the first week of the month? Does the program buy them food for the rest of the month?*
- *To let all individuals have access to all food 24/7, 365 days a year is not supportable financially or medically. The food in any house where multiple individuals live must be shared. Is the State and CMS looking adding more locking refrigerators? How is that home like?*
- *Unfettered access to food may be extremely detrimental to medically fragile individuals, result in obesity for others, be extremely costly for participants, and mandate an immediate staff presence for individuals who need assistance with cooking requiring on-demand staff and therefore increased funding.*
- *When *** came to Mountain Regional she was close to the end of her life. She was obese, 325 lbs, the organization in Sheridan could not control her eating because they did not have locked cabinets AND the clients were free to eat at will. She was put in the hospital and on to a nursing home. I was advised to take guardianship and contact the Advocacy group out of Cheyenne. I received immediate attention and within a week I was notified that a place had been located that could care for ***, Mountain Regional in Evanston. *** received immediate care from a staff nutritionist. Eighteen years later the quality of ***'s life is the best she has ever had. She is at a healthy weight, she has a job (13 years), she lives in a home that she feels safe in, that I visit every year and know it is "home" for her. She has roommates that she can communicate with, interact with and socialize with. Every day she is in a center where she participates in activities and socializing....and is safe. The staff that have worked with *** over the years are the main reason *** is still with us today. ***'s needs require close supervision and monitoring, over the years *** has grown and learned. She is not the same person she was before MRS. And that is not just a coincidence, she has a plan of care that has been developed and reworked and reworked, she has professionals that care for her and monitor her daily activities. She has health providers that monitor and care for her, she has mental health care that teaches her how to interact with others and understand some of her own feelings. It is so discouraging to hear of the changes that are being proposed by people that probably have no idea of the journey some of us have been through with our loved ones that are not equipped to travel life on their own.*
- *In considering the "new rules" regarding food. I have always been supportive of menu planning and portion control. I do this in my own life, in my own home, and I do this for a reason. I am not exceptionally overweight, and I am generally in good health. Of course, I am only stable in this area because I have self-discipline. Can you honestly tell me that the population we serve are capable of making healthy decisions regarding what to buy, when to eat, and what to eat. It was said to me, by Division staff, that if a participant chooses to eat all of their food for the week over the weekend, then this would be a natural consequence. Are you kidding me?! In raising my kids, I cooked dinner every night, the same dinner for all of us, and we sat down at the table and we ate as a family. Does CMS or the Division believe that the structure around food and meal times, as it is in most places, is not based on good old fashioned family values? Are we not further separating, or alienating the Prader-Willie patient when we have to restrict her rights to food, lock the food up for her health and safety, and then give everyone*

	<i>else a key? How would you feel if this was you? Talk about a slap in the face.</i>
STATE RESPONSE	<p>The Transition Taskforce talked in length about concerns with the “access to food” requirement. This standard may be an adjustment for several providers. The new standards uphold the person’s right access to the typical facilities in a home, such as the kitchen, dining area, laundry, and comfortable seating/lounging areas, choose when and what to eat and have access to food at any time, and chooses with whom to eat or to eat alone. Not any one disability or diagnosis requires a specific restriction to food. Portion control and concerns with over-indulging in food purchased early in the month can have different practices put in place to help mitigate those risks without just restricting access. Participants may need goals to work on proper budgeting, nutrition, portion control, etc. and they may need to have more activities and exercise options in their day that will deter them from wanting to overeat. The rules stress the importance individualized services based on the person’s needs and preferences. Also, other participants in the home should not have a restriction imposed on them if a different housemate has the need for a restriction. This will be an area that the state and providers will need to research further in order to find successful practices that “assist with food, meals, and keep enough food available throughout the month” rather than using restrictive practices, such as locking up all food.</p> <p>As a reminder, if a participant who has a need for one of the rights to be restricted, the person’s team must make decisions based on that person’s assessed need for a restriction and not base a decision solely on a diagnosis, medical condition or a possible behavior that happens on occasion. The rules specify that any modification or restriction of the additional conditions, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan. The provider must document the positive interventions and supports used prior to any modifications to the person-centered service plan, use and document less intrusive methods of meeting the need that have been tried but did not work and include a clear description of the condition that is directly proportionate to the specific assessed need.</p>
COMMENTS RECEIVED	<p><i>Other concerns with how to modify rights</i></p> <ul style="list-style-type: none"> <i>How do you address restrictions like swimming when a person has regular seizures?</i> <i>I am assuming that the idea that least restrictive approaches be used first EVERY TIME must be referring to restrictions due to behavior. It would be demeaning, for instance, for a staff to have to encourage a person who has no use of his arms to try to shower himself before staff could offer to help him.</i> <i>With all the emphasis on freedom and involvements, participants still need protection from exploitation and abuse. Community and family members involved with some of the MRSI participants before they came to MRSI were extremely abusive.</i>
STATE RESPONSE	<p>The rules do allow for modifications/restrictions to a person’s rights, but the restrictions must be specific to a need (not just a diagnosis or disability) and be written into the plan of care. The rules specify that any modification or restriction of the additional conditions, under § 441.301(c)(4)(vi)(A) through (D), must document the following in the plan of care:</p> <ul style="list-style-type: none"> Identify a specific and individualized assessed need. Document the positive interventions and supports used prior to any modifications to the person-centered service plan. Document less intrusive methods of meeting the need that have been tried but did not work. Include a clear description of the condition that is directly proportionate to the specific assessed need. Include regular collection and review of data to measure the ongoing effectiveness of the modification. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated. Include the informed consent of the individual. Include an assurance that interventions and supports will cause no harm to the individual.

Conflict Free Case Management concerns in the new rule

- *So why can't we choose the Case Managers that we already have? Why must we go Conflict Free? What about choice?*
- *Didn't last legislation as the State to request a Variance on Conflict Free Case Management?*
- *One of the hard things is my Brother In-Law had the same Case Manager for 20 years. Why can't she still be his Case Manager?*
- *Does the conflict free case management apply to the long term care waiver?*
- *How will we address the issue of case management and nursing care for the long term care waiver?*
- *Conflict free case management is not choice, or sustainable financially after January 1, 2015. And is gets even less sustainable after July1, 2015!*
- *I would like to address the changes to Case Management. I am saddened that CMS and the Division feel they know what is best regarding Case Management services for the participants on my case load, on any Case Manager's case load. I am saddened that my job is basically being ripped out from under me. I am saddened that the reason I feel I have done my job so well is because I was given the opportunity to be involved, I mean really be involved, because I have constant, almost daily contact with the folks I serve. It takes commitment, compassion, and total investment in the quality of life of another human being to do the true job of Case Management. We are instructed, and responsible, to know every detail, every dealing, every in-and-out of daily life, everything we can to improve the quality of life while still ensuring the health and safety of the people for whom we provide Case Management services for, and yet, we are called conflicted. I'm wondering why whether to have and in house Case Manager or an outside Case Manager should not be the choice of the Guardian. Several of my Guardians chose me as their ward's Case Manager because I was in house and they knew, they knew that my daily involvement was going to make a huge difference in the life of their ward. I believe if CMS or the Division believed that Case Management services were so important, so instrumental, in the lives of the participants, than these services would not have been changed. Maybe in house Case Managers are somewhat conflicted because they believe in the program's they work for. If they didn't, would they really work for them? Maybe the system is broken, maybe the provider should be chosen, and then the Case Manager. Case Managers have huge responsibilities, some may even say they are the center of the wagon wheel, yet we are being told that we can't do our job the way we feel we could do it best. Furthermore, the Case Management rate has been cut so far, it is impossible to be able to afford to continue in the position. I believe is going to be lacking the needed personnel to fulfill one of the most, as the Division describes it, important services on the waiver. If Case Management is so important, why the \$10.90, 15 minute rate? If you want Case Manager's to continue to provide Case Management services, pay them what they are worth. Keep the monthly unit, get rid of the 15 minute unit, and pay for the service. I'm sick of hearing kudos for Case Manager's from the Division. The "we can't thank you enough for your services" is over-rated and has expired. If you want Case Manager's to continue to do the job that you say you are so grateful for, then let them do their job the best way they know how to given their case load, whether that's in house, or outside. I feel you thank us so much because you know we are being taken advantage of, and the bottom line is that you need Case Manager's to continue to do the same work, if not more, for less pay. Very, very sad that this is where we find ourselves.*

**COMMENTS
RECEIVED**

**STATE
RESPONSE**

Conflict Free case management is a specific requirement in the new federal rules. We can only ask CMS for an exception in an area where a certified case manager without a conflict cannot be found who is willing and able to serve the participant. We cannot ask for an exception for the whole state.

The Division is monitoring the availability of case managers to provide statewide coverage. If the Division finds an area that is not sufficiently covered, the Division will work on advertising for providers to enroll through the available means specific to that area.

Based on other public comment received, the 15 minute unit will be available, as well as the monthly unit of case management, until the rates can be rebased. Please check our website to see the update on this announcement.

We understand that moving to conflict free may result in some case managers changing professions or changing caseloads in order to resolve his or her conflict of interest. The method in which the state is transitioning to conflict free involves several steps within the transition year, and hopefully

any participant who is changing case managers will find another case manager who meets their needs as much as the last one. The state's transition to conflict free case management was designed by several people in the field and at the state and was out for public comment for several months last year. The practice of conflict free case management should ensure the quality of the plan of care developed and the delivery of services. It increases the level of advocacy and authority a case manager has while monitoring the implementation of the plan of care. Although the transition will be difficult, we hope everyone can find a great case manager. Please contact the Division if concerns with your case management services arise.

TOPIC	Comments on State Standards
COMMENTS RECEIVED	<p><i>The person is supported by a team member to interview providers and find out information to help make an informed choice.</i></p> <ul style="list-style-type: none"> <i>Agree with the concept but have concerns regarding definition of who on the team will be a qualified to assist and what tool will be used to document informed choice to ensure objectivity.</i>
STATE RESPONSE	<p>The case manager will need to help facilitate this process. We can research the tools used in other states that ensure objectivity.</p>
COMMENTS RECEIVED	<p><i>A person, who uses non-verbal or limited communication, is encouraged to express choice through gestures, actions, behaviors, and strengths in order to have choices honored.</i></p> <ul style="list-style-type: none"> <i>How will this input be measured and what tool will document this. Agree with concept, but practicality may be difficult to implement and measured due to the severity of disability, functioning age, comprehension limited, etc. Will the guardian be considered person served when in all reality the person is unable to make informed choice independently?</i>
STATE RESPONSE	<p>The plan of care should include the process the team uses to offer choice to a person who uses non-verbal communication so that everyone is supporting the person consistently and helping them to practice as much self-determination as possible. There will likely be no specific tool other than satisfaction surveys and observations of the person receiving support to make choices. As we find people who do this well, the state will share practices and ideas with other providers. The guardian still can help choose for the participant in areas that are defined in the court documents. However, on day to day choices when the guardian is not there, the participant must be able to practice and exercise choice to the fullest extent possible.</p>
COMMENTS RECEIVED	<p><i>The person is involved in the community and has regular, unscheduled access to the community to the same degree of access as people who are not on Medicaid.</i></p> <ul style="list-style-type: none"> <i>Again, agree with the concept but implementation may be unattainable, setting up both the provider and State of Wyoming to fail and be out of compliance with our own established standards. Will the State of Wyoming fund services at the rate necessary to have additional staff accommodate every waiver participant in accessing the community basically anytime they want? Many individuals do not have natural supports to fill this void. Another example is the supervision required for individuals. For example, people with mobility limitations, sex offenders, and persons with limited safety skills would need supervision that may not be funded.</i>
STATE RESPONSE	<p>The state will have to work with all stakeholders including legislators to evaluate the rates for services and the outcomes we need to see based on the new rules. We will have to see modifications</p>

	<p>to services in order to meet this area of compliance, but we realize that funding may be a concern. The state will continue to bring in technical assistance to help us improve our service system to meet the new standards, and we will keep these standards in mind as we do our upcoming rate rebasement.</p>
COMMENTS RECEIVED	<p><i>The person has meaningful relationships in his or her life, some of which are with people who do not have disabilities or are not paid staff.</i></p> <ul style="list-style-type: none"> <i>Who will define meaningful relationships? What are the consequences if “meaningful relationships are not established? What is the time frame to establish “meaningful relationships”?</i>
STATE RESPONSE	<p>The meaningful relationship may be with people the person already knows, like other participants and staff. The person should be able to make friends with people who are non-staff and have people who are non-staff that they care about and can visit with. The integration standard focuses on increasing the options and support for people to be a part of the broader community. Meaningful relationships may start in different ways, but almost always they start with a one-to-one interaction and conversation. Individualized services that link participants to people with like interests or a common goal will help participants have more acquaintances and friendships in their lives. As we move forward, meaningful relationships will be measured using interview information and observations as much as possible. As the state learns from other providers and other states about how to gauge compliance with these standards, more information will be released.</p>
COMMENTS RECEIVED	<p><i>The person, regardless of age, is supported in volunteer efforts to help participate and be an active, contributing member of their community.</i></p> <ul style="list-style-type: none"> <i>What if people do not want to participate in volunteer activities like many non-disabled people? What if age limits ability to volunteer?</i>
STATE RESPONSE	<p>The expectation of volunteers is connected to the integration standards and the pathway to employment. There may be some barriers to certain types of volunteering, but the act of volunteering is a key component of helping to address the culture change that needs to occur for full integration and inclusion to be a reality. Both the public and the individual with a disability benefit from being a part of contributing to the greater good of the community.</p>
COMMENTS RECEIVED	<p><i>New standards for setting locations</i></p> <ul style="list-style-type: none"> <i>On the grounds of or immediately adjacent to other facility -We have 2 sites of concern. One has 2 group homes next to our Day Hab building. Every building was built with WCDA or CDBG funds. The second one is a building that has Day Hab on one side and group home on the other. This building is across the street from our admin/employment building.</i> <i>Does this apply to day programming or just residential? We understand if this applies to residential. However, if this applies to day programming we adamantly oppose the language. We do not feel this is the intent of the CMS rules and feel is once again over stepping its responsibilities and implemented standards that are rigid and could have many negative financial and program consequences that are unnecessary.</i> <i>For example, CES has day habilitation location that is in a technical/professional park, not an industrial park. Who makes this call? This building is also adjacent to Central College and directly across the street from a public high school, which by definition are public institutions. Who makes this call? We use the college campus and convenient access to provide integrated activities and classes, make sense.</i>

STATE RESPONSE

Based on the comments received, we have modified the settings analysis to eliminate ruling out a setting due to being adjacent to other facilities that serve participants, an industrial park or commercial zoning location. They will either be in the “do not comply without modifications” or the “presumed non-HCBS but we will submit evidence to ask for approval.” Wyoming’s transition plan outlines a process of assessment that will be based on examining the characteristics of HCBS rather than relying solely on location, size, physical structure, or geography. Compliance will be determined based on the opportunities and experiences of the members receiving HCBS, according to the standards set in the federal regulation, including but not limited to whether the individual has selected the setting from all available choices; whether the individual’s rights to privacy, dignity and respect, and freedom from coercion are protected; whether the individual has choice in services and providers; whether the setting is integrated in and facilitates the individuals access to the greater community; whether the person has a choice of roommates, has freedom to control their own schedules and activities, and may have visitors and access to food at any time.

CMS states the participant should receive services “in a location among other private residences and retail businesses, in an area with consistent traffic patterns and where visitors are present and visiting regularly”. The state will take a person’s “experiences” into account as part of the setting analysis. These other “location” and “segregation” characteristics must also be factored in, but alone, will not determine a place to be out of compliance.

There has not been additional guidance for non-residential settings, so at this time we are using the same standards in the rule. As more CMS guidance is released for non-residential settings, the state will rely on the federal regulation and the accompanying guidance issued by CMS to define and explain these terms. In developing these aspects of the regulation, CMS considered the qualities most often articulated by persons with disabilities as key determinants of independence and community integration, which includes that the setting:

- Supports full access to the greater community to the same degree as individuals not receiving Medicaid HCBS.
- Is selected by the individual from options including non-disability specific settings.
- Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
- Optimizes individual independence in making life choices including daily activities, physical environment, and with whom to interact.
- Facilitates individual choice regarding services and supports, and who provides them

FINDING THE WAIVER SPECIFIC TRANSITION PLANS

The updated five-year transition plan for the Department’s Assisted Living Facility, Supports, Comprehensive, Child Developmental Disabilities, and Acquired Brain Injury Waivers are on the Department’s website at <http://health.wyo.gov/healthcarefin/equalitycare/index.html>.